MEDICAID Managed Care Provider Manual



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<u>STATE PLAN AMENDMENT</u> – TITLE XIX OF THE SOCIAL SECURITY ACT

South Dakota Medical Assistance's Managed Care Program, Provider and Recipient in Medicaid Efficiency Program (PRIME), is based on the primary care case management (PCCM) model. The Program is operational statewide, is applicable for recipients eligible under Title XIX and Title XXI of the Social Security Act and is administered by South Dakota Department of Social Services Division of Medical Services. Reimbursement is based on fee for service plus a monthly case management fee.

The basic concept is to allow Medical Assistance enrollees to select one primary care provider (PCP). The PCP will provide, through an ongoing patient/physician relationship, primary care services and referrals for all necessary specialty services. The PCP is responsible for monitoring the health care and utilization of managed care covered services. All services, other than the case management fee, are billed and reimbursed to the provider who renders the service.

GOAL:

The South Dakota Medicaid Managed Care program is serving as a Primary Care Case Management model. The Managed Care program is designed to improve access and availability and continuation of care while reducing inappropriate utilization, over utilization, and duplication of Medicaid covered services while operating a cost-effective program.

DEFINITIONS

Primary Care Provider (PCP) - One provider chosen by the recipient or assigned by department staff to provide primary care and case management services. All Medicaid Managed Care eligible recipients receive written verification of any selection, assignment, or change of a PCP through either the Notification letter or the Assignment Notice.

Designated Covering Provider (DCP) - When a managed care recipient's PCP is unable to see the recipient (i.e. - called to surgery, vacation, delivery, etc.) another Designated Covering Provider within the same facility or outside the facility but with an arrangement with the PCP will be allowed to essentially "ACT" as the recipient's PCP. This is called a COVERAGE referral and referral/authorization documentation is not required.

Referral/Specialty Provider - A provider who is NOT the recipient's PCP, but who is providing medically necessary Medicaid covered services through a referral/authorization by the recipient's PCP or Designated Covering Provider. Medicaid covered services provided by a referred/specialty provider without referral/authorization by the recipient's PCP are non-covered services--unless the service is determined to be an emergency, or exempt from Managed Care.

Satellite PCP - A PCP who is a recipient's PCP at another location (self-referred).

Emergency Care - An "emergency medical condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) <u>Placing the health of the individual (or, with respect to a pregnant woman, the</u> health of the woman or her unborn child) in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

Emergency services do not require prior PCP authorization and may be provided by any Medicaid provider.

Referral Card/Authorization - This is essentially a PCP's or a Designated Covering Provider's "prescription" for medically necessary Medicaid Managed Care covered specialty services. A referral/authorization is given when a specific condition requires the recipient to receive medically necessary Medicaid managed care covered specialty services outside of the eligible recipient's PCP. The referral card is designed to serve as a tool for the South Dakota Medicaid Managed Care program. The card provides an example of the information required to both provide and receive a proper referral/authorization under the program's rules and regulations. As long as the mandatory referral/authorization information is received and documented prior to the service, the physical card is not required. Other examples of acceptable referrals include a letter from the PCP, hospital admittance letters, (CMN) Certificates of Medical Necessity and verbal/telephone authorizations. Appropriate documentation for a verbal/telephone authorization includes: who verbally authorized services, the PCP's name and seven digit South Dakota Medicaid identification number, date of authorization, time frame of authorization (not to exceed one year), and the condition authorized for treatment. The PCP's name and seven digit ID number can also be indicated on a physician order for specialty services to indicate proper PCP referral/authorization.

MANAGED CARE PRIMARY CARE PROVIDERS (PCP):

THOSE WHO MAY PARTICIPATE AS A PRIMARY CARE PROVIDER

- 1. Family and General Practitioners
- 2. Pediatricians
- 3. Doctors of Internal Medicine
- 4. OB/GYN's
- 5. Clinics certified as a Rural Health Clinic
- 6. Clinics certified as a Federally Qualified Health Center
- 7. Clinics designated as an Indian Health Clinic

BENEFITS TO PARTICIPATING PHYSICIANS:

The program extends primary care provider efforts as Medicaid providers to encourage continuity of care, monitor utilization, and track specialized health needs of patients as well as allowing all primary care providers to have a specific Medicaid volume and practice. In addition, each month participating physicians will receive a case management fee of \$3.00 for each recipient who is enrolled with that physician, regardless of whether the physician has provided services to that recipient during the month. Moreover, for services rendered by primary care physicians, to recipients who have chosen that physician (i.e., recipients on that physicians monthly primary care caseload), the Program has made an additional provision to include any applicable cost-share amount into the payment for services.

HOW THIS PROGRAM WORKS:

Only those primary care providers who take the initiative to enroll in the managed care program will be allowed the opportunity to serve Medicaid managed care recipients without the need for a referral or authorization. As an enrolled Primary Care Provider you will receive a list of Medicaid recipients who have selected you as their provider. You will provide comprehensive primary health care services for all eligible Medicaid recipients who choose or are assigned to your practice. As their case manager, you will refer (authorize) recipients for other care only when medically necessary. Managed Care covered services not authorized by you will no longer be paid by Medicaid. You must also provide 24 hour, 7 days a week access by telephone which will immediately page an on-call medical professional to handle medical situations during non-office hours. If you are affiliated with a calling network to serve as your non-office hours contact, this may be utilized for general call purposes only. Any referrals given to recipients through these calling networks (i.e., referring individuals to seek medical attention at the emergency room) must be prior approved by the recipient's Primary Care Provider or the Designated Covering Provider.

HOW TO ENROLL

Enclosed is an addendum to your current Medicaid Provider Agreement which details the responsibilities and requirements under managed care. If you wish to participate in the Managed Care Program, please complete the <u>Addendum to the Provider Agreement</u> which is located at the back of this provider manual.

MANAGED CARE RECIPIENTS:

The following Medicaid eligible recipients are required to participate in the Managed Care program:

- 1. Temporary Assistance to Needy Families (TANF)/Low Income Families (LIF)
- 2. Child Health Insurance Program (CHIP)
- 3. Low-Income Children and Pregnant Women
- 4. SSI-Blind/Disabled

Essentially, three-fourths of the South Dakota Medicaid population is participating in the Managed Care program.

BASIC MEDICAID RECIPIENTS:

The following Medicaid eligible recipients are <u>NOT</u> required to participate in Managed Care. These recipients receive BASIC Medicaid:

- 1. Home and Community Based Services
- 2. Nursing Home Residents
- 3. Adjustment Training Center Residents
- 4. Medicare/Medicaid eligible
- 5. Foster Care Children
- 6. Subsidized Adoption Children

IHS RECIPIENTS:

Native American recipients may choose but are not required to choose Indian Health Services (IHS) as their PCP. If they do not choose IHS as their PCP they can still receive services at an IHS facility without a referral from their PCP. When IHS is unable to treat the recipient because they require more specialized services they may refer the recipient to another provider. If the referred provider is an IHS Contract Care provider, meaning they have an active contract with IHS, then the services they provide to the recipient are outside of Managed Care requirements. Any further referrals directly related to the original IHS referral are also outside of the Managed Care requirements. Referrals made from IHS to a non-IHS Contract Care provider must meet the proper referral/authorization requirements of the South Dakota Managed Care program.

HEALTHY KIDS KLUB SCREENINGS:

When possible the Healthy Kids Klub screenings should be performed by the recipient's PCP but this is not a mandatory requirement. An effort should be made to complete these screenings when the opportunity presents itself. If the child is being seen for an unrelated illness/injury and is due for a Healthy Kids Klub screening an effort should be made to complete the screening at the same time.

SPECIAL SERVICES--SED/SPMI MENTAL HEALTH SERVICES:

Medicaid eligible recipients diagnosed as SED (Severely Emotionally Disturbed) or SPMI (Severely and Persistently Mentally III) by their mental health professional are excluded from the Medicaid Managed Care program for Mental Health Services ONLY. Authorization from the Primary Care Provider for ALL other Managed Care services is required.

MANAGED CARE OVERVIEW:

Medicaid Managed Care recipients are trained on the Managed Care program by local Department of Social Services staff. Training occurs during the initial application process and annually during a review of their case. Recipients are provided a list of participating PCP's and are informed of their responsibility to select a PCP for each eligible Medicaid Managed Care recipient in the household. Recipients who fail to select a PCP are assigned a provider by Medicaid Managed Care staff. A PCP selection or assignment may be changed by the recipient or the Primary Care Provider. The PCP selection or assignment remains in effect until one of the following occurs:

- 1. The recipient submits a change request during their annual redetermination of eligibility.
- 2. The recipient submits a change request showing "good cause" for such a change including specific details.
- 3. The Primary Care Provider submits a written request explaining why they want this recipient removed from their caseload.*

*The current PCP will remain that recipient's PCP for the remainder of the month if the request is received prior to the 15th of the month. For requests received after the 15th of the month, the current PCP will remain that recipient's PCP through the following month to give that recipient adequate time to choose another PCP. The PCP should refer the patient to another provider for medical services through this interim period.

Recipients receive training on Medicaid Managed Care covered services, exempt Managed Care services, emergency room services and the referral process. All recipients are provided with a Managed Care recipient brochure which further explains their responsibilities under the Medicaid Managed Care program and lists phone numbers to call if they have any questions.

Once the Division of Medical Services enters the Primary Care Provider information onto the recipient's Managed Care record the recipient will receive a system-generated notice. At the bottom of each notice is a perforated paper card which indicates each Managed Care recipient's PCP for the following month along with the PCP's phone number.

NOTE: All approved Medicaid recipients who qualify for the Managed Care Program will not be entered into Managed Care until the first of the next month following the month of approval.

MANAGED CARE SERVICES:

The following Medicaid covered services require a referral/authorization from the recipient's Primary Care Provider. If these Managed Care covered services are not provided by the recipient's PCP, a referral/authorization is required prior to services being performed.

- 1. Physician/Clinic Services
- 2. Inpatient/Outpatient Hospital Services
- 3. Home Health Services
- 4. Rehabilitation Hospital Services
- 5. Psychological Treatment
- 6. Psychiatry/Psychology
- 7. Prescription Drug Services (Including Podiatric, Optometric, and Chiropractic Prescriptions)
- 8. Durable Medical Equipment Services
- 9. School District Services
- 10. Ambulatory Surgical Center Services
- 11. Healthy Kids Klub Visits (screening)
- 12. Mental Health Services
- 13. NP's, PA's, and Nurse Midwives
- 14. Residential Treatment
- 15. Ophthalmology (medical complications, Non-routine)
- 16. Therapy (Physical/Speech)
- 17. Community Mental Health Centers
- 18. Pregnancy- related Services
- 19. Lab/X-Ray Services (at another facility)

NON-MANAGED CARE SERVICES:

The following Medicaid covered services are exempt from the Managed Care program. The Medicaid eligible recipient does NOT need a referral from their Primary Care Provider to access these Medicaid covered services.

- 1. "True" Emergency Services (and related pharmacy)
- 2. Family Planning Services (and related pharmacy)
- 3. Dental/Orthodontic Services (and related pharmacy)
- 4. Chemical Dependency Treatment
- 5. Podiatry Services
- 6. Optometric/Optical Services (Routine eye care)
- 7. Chiropractic Services
- 8. Immunizations
- 9. Mental Health Services for SED/SPMI recipients (and related pharmacy)
- 10. Ambulance/Transportation
- 11. Anesthesiology
- 12. Independent Radiology/Pathology
- 13. Independent Lab/X-Ray Services *(when sending samples or specimens to any outside facility for analysis only).

<u>MANAGED CARE EXEMPTIONS</u> (<u>MEDICALLY FRAGILE</u>)

Under certain circumstances, a Managed Care recipient's medical condition may warrant the direct care and supervision of a specialist, i.e. psystic fibrosis, premature baby. Due to the special needs of these recipients, the principle specialist may request an "Exemption" from the Managed Care Program on behalf of the recipient to allow the specialist to serve as the recipient's case manager. Exemptions are reserved for patients diagnosed with life threatening multi-organ chronic conditions, in which the patient's total medical care revolves around their predominant medical problem.

The specialist must agree to three specific requirements before Medicaid will consider excluding the patient from Managed Care:

- 1. Agree to be available and accessible to the patient 24 hours a day, 7 days a week.
- 2. Agree to refer/authorize the patient to outside facilities for medically necessary services they cannot provide.
- 3. Agree to have a case management mechanism in place to follow in managing the patient's care.

These requirements must be confirmed in writing along with a description of the patient's medical condition. Upon approval of the exemption by the Department, the requesting physician may serve as the case manager for the patient until such time as the specialized care is no longer required, or one year has passed. The Department must receive written notification of either occurrence so the appropriate steps can be taken to reenter the patient into the Managed Care Program or extend the initial exemption another year.

South Dakota Medical Assistance Hospital Emergency Room Services Guidance Memorandum

South Dakota Department of Social Services, Division of Medical Services utilizes the Prudent Layperson definition for the determination of an "emergency medical condition".

The determination of whether the Prudent Layperson standard has been met must be focused on the <u>presenting symptoms</u> (and not on the final diagnosis), and must take into account that the decision to seek emergency services was made by a prudent layperson (rather than a medical professional).

Emergency Definition

An "emergency medical condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part

Note: The physician, PA, or NP on duty or on call at a hospital must determine whether the individual requires emergency hospital care. Emergency hospital services does not include that care for which treatment is available and routinely provided in a clinic or physician's office.

Emergency services are outside of the managed care program. When a Medical Assistance managed care recipient requires emergency care, a referral/authorization is not required.

EMTALA and the BBA

Under the Emergency Medical Treatment and Active Labor Act (EMTALA), Medicare participating hospitals that offer emergency services are required to perform a medical screening examination on all people who come to the hospital seeking emergency care. If an emergency medical condition is found to exist, the hospital must provide whatever treatment is necessary to stabilize the condition.

Under managed care provisions of the Balanced Budget Amendment (BBA), the Centers for Medicare & Medicaid Services (CMS) set forth specific guidelines on when Primary Care Case Management (PCCM) medical assistance programs are responsible for payment. Determination is as follows:

<u>Presence of a Clinical Emergency</u> -- If the examining provider determines that an actual emergency medical condition exists, Division of Medical Services is required under the BBA to consider for payment all services involved in the screening examination and those required to stabilize the patient. Division of Medical Services takes this one step further and considers for payment all medically necessary services utilized for screening, stabilization and treatment of true emergency conditions (**Code "E" or "1" – emergency**).

<u>Absence of a Clinical Emergency</u> -- If the examining provider determines that an actual emergency medical condition does not exist, the Prudent Layperson standard must be followed. The determining factor for an emergency condition should be whether the recipient had acute symptoms

of sufficient severity to have warranted emergency attention at the time of presentation. In these cases, Division of Medical Services will consider for payment all medically necessary services utilized for screening, stabilization and treatment (**Code "E" or "1" – emergency**). If the presenting symptoms do not meet the Prudent Layperson standard, yet the hospital must meet their EMTALA requirements, Division of Medical Services will consider for payment the ER room charge and physician examination charge (**Code "U" or "2" – urgent**). Recipients in this situation may be responsible for the remainder of the charges. Elective care (**Code "3"**) is not emergent or urgent and must be PCP referred.

<u>Referrals</u> -- When a recipient's primary care physician instructs^{*} the recipient to seek emergency room care, Division of Medical Services will consider for payment the medical screening examination and other medically necessary emergency room services, without regard to whether the patient meets the Prudent Layperson standard described above

Duration of Emergency Service

All medical services related to an emergency admission and provided on the premises are considered emergency services through discharge. This includes consultant services, prescriptions, therapy, hospital transfers, etc. Upon discharge all medically necessary follow-up services incidental to an ER visit must be PCP referred/authorized. The recipient's PCP will determine the need for specialty and follow-up treatment.

^{*} Verification of referrals is required. This usually consists of a telephone confirmation between the hospital and the PCP or designated covering provider (DCP). The confirmation must be documented.

PRIMARY CARE PROVIDER CASE MANAGEMENT

Reports:

Medicaid has developed specific reports to aid Primary Care Providers in their responsibilities as case managers for their Medicaid Managed Care caseloads. The Division of Medical Services strongly urges the monthly review of these reports by PCPs.

- <u>Caseload List</u> received the first week of each month. Lists all Medicaid Managed
 Care recipients assigned to a PCP's caseload for the current month. Recipients who are
 reinstated during the month will not appear on the Caseload List but will still have that
 PCP.
- 2. Paid Claims Report received monthly with the Caseload List. This report lists each Managed Care recipient in alphabetical order who Medicaid paid a Managed Care claim for in the previous month. It also lists all prescription drugs (managed care and non-managed care) for PCP reference. The purpose of Monthly Paid Claims Reports is to assist PCPs in case managing the medical care of their managed care participants. The reports should also be used to identify unauthorized managed care services. Although close analysis is not expected, we recommend that PCPs review the reports each month to provide them an overview of services and referral activity of their caseload. Please contact this office if you discover unauthorized services on this report.

SOUTH DAKOTA MEDICAID MANAGED CARE

IDENTIFICATION CARD

MIC (Medical Identification Card)

1. What does the card look like?

It is a magnetic stripe plastic card with the same background as the Food Stamp EBT card. The information on the face of the card will be the complete name (first, middle initial, last), RID# (recipient identification number - 9 digits) plus a three digit generation number ***, date of birth, and sex. Each individual household member is issued their own card.



IMPORTANT

***Generation number: This is a number that is automatically added in the system to indicate how many cards an individual has been sent. For example, the very first original plastic card would have a generation number of 001. If the client reports a card is lost the next card would have a generation number of 002, etc. The generation number is **not part of the individual's ID#.**

2. How are the cards produced/ordered?

A card will be generated and mailed to eligible individuals within two (2) days of approval for the Medicaid program.

Recipients are to report lost, stolen or damaged cards to their Benefits Specialist/clerical. The Benefits Specialist/clerical will have the capability to "order" replacement cards.

3. How does the provider determine eligibility?

The Medicaid Identification Card does not guarantee Medicaid eligibility. The provider is responsible for verifying eligibility.

WebMD Envoy, our contracted information provider, offers three options to verify eligibility information. The three options are:

- Point-of-service terminal (swipe device similar to credit card verification) which may be purchased or leased
- Personal computer software
- · Secure Web based site

All three options provide prompt response times, printable receipts and can verify eligibility status for prior dates of service. There is a nominal fee for each verification obtained through WebMD Envoy.

The alternative to electronic verification is to use the SD Medical Assistance telephone audio response unit (ARU) by calling 1-800-452-7691. Each call takes approximately one minute to complete and this system is limited to current eligibility verification only.

For more information about the MEVS system, contact WebMD Envoy at 1-800-735-8254, press "0" and ask for Enrollment or visit WebMD Envoy's Web site at www.webmd.com.

4. What eligibility information will the provider receive?

Through the MEVS (swipe or PC key entry) the provider will receive a "receipt ticket" in their office immediately upon eligibility verification (10 seconds). The following is an example of the "ticket" sent to the provider.

**************************************	· ·		
PATIENT IS ELIGIBLE	Y/N		
Date of Service:	01/19/97		
Provider ID#:	0123457		

Verification Number	blank/or #		
Name:	Jane Doe		
RID#:	000045789		
Card Generation #:	001		
DOB/(age):	04/11/73 (26)		
Sex:	$\dot{\mathbf{F}}$		
Restriction:	Limited to pregnancy services only		
Co-Pay:	Y		
*********	Managed Care****************		
Managed Care:	Y/N		
PCP Name:	Smith,JD		
PCP Telephone #	605-123-4567		
T************	hird Party Liability***************		
Medicare/HIB#	123-45-6789A		
Coverage code:	PHI3		
Policy Number:	AA1234		
Carrier Name:	Hartford		
Address:	123 S. Main		
City/State/Zip	Hartford, CO. 12345		
Phone #	605-123-4567		

SOUTH DAKOTA MEDICAID MANAGED CARE REFERRAL/AUTHORIZATION

PROCEDURES

Medicaid Managed Care Referral Card

I'm referring (authorizing)		t
	(Recipient Name)	
		_ for medically
(Specialty Provider)		
necessary Medicaid covered	limits services to three (3) months or le	service
Primary Care Provider Name/Phone Number	Primary Care Provider Medicald ID #	
	Primary Care Provider Medicald ID 8	
Primary Care Provider Mailing Address	Primary Care Provider Medicaid ID #	
Primary Care Provider Name/Phone Number Primary Care Provider Mailing Address Amending Physician Signature/Authorization Signature of Specialty Provider		

MANAGED CARE SERVICES REFERRAL/AUTHORIZATION IS REQUIRED

Physician/Clinic
Psychiatry/Psychology
NP's, PA's
Residential Treatment
Nurse Midwives
Durable Medical Equipment
Ophthalmology (or refactive)
Therapy (Physicas/Beech)
Community Mental Health Center
Inpatient/Duptatient Hospital Services
Pregnancy Related Services
Arnibulatory Surgical Center
Prescription Drugs (when wrise by other
ham PCP agn et emerger)
Lab/X-Ray Services (at another facility)

NON-MANAGED CARE SERVICES REFERRAL/AUTHORIZATION IS NOT REQUIRED

True Emergency Services
& related pharmacy
Family Planning & related pharmacy
Dental Services & related pharmacy
Optometric (Routine eye care)
Podiatry
Ambulanco/Transportation
Anesthesiology
Chiropractic
Independent Radiology/Pathology
Immunizations
Chemical Dependency Treatment
*Independent Lab/X-Rays
("when secting samples or
specimens to any outside facility
for analysis orth)

MEDICAID WILL ONLY PAY FOR MEDICALLY NECESSARY COVERED SERVICES AUTHORIZED BY THE PRIMARY CARE PROVIDER. MANAGED CARE SERVICES PROVIDED WHICH ARE NOT AUTHORIZED WILL BE THE RECIPIENT'S RESPONSIBILITY TO PAY.

SOUTH DAKOTA MEDICAID MANAGED CARE PROGRAM

REFERRAL CARD/AUTHORIZATION

PCP Referral/Authorization

The referral card/authorization is essentially a "prescription" for specialty provider managed care covered services. When a South Dakota Medicaid managed care recipient requires medically necessary Medicaid managed care covered services, the eligible recipient's initial contact is with their PCP. The PCP or Designated Covering Provider (DCP) issues a referral/authorization when the condition of the recipient indicates medical necessity for Medicaid managed care covered services from someone other than the eligible recipient's PCP. A referral/authorization permits the eligible recipient to see a referred specialty provider for medically necessary Medicaid covered services for a specific condition. The referral/authorization is valid for a time frame indicated on the referral card or by verbal authorization (not to exceed one year). The referral/authorization must include the PCP's name/phone number and the PCP's seven digit South Dakota Medicaid identification number. The PCP or Designated Covering Provider (DCP) signs and dates the referral. If a DCP refers/authorizes services, the referral/authorization must contain the recipient's PCP name and seven digit South Dakota Medicaid number as indicated in their eligibility information.

Further Referral/Authorization by Specialty Provider

When medically necessary, a specialty provider may refer the recipient for further Medicaid managed care covered services. A further referral/authorization can only be extended within the original time frame initially authorized by the recipient's PCP (not to exceed one year) and within the original condition authorized. The eligible recipient will take the signed and dated referral card or other appropriate documentation such as a letter from the recipient's PCP, hospital admittance letter, (CMN) Certificates of Medical Necessity, with them to the next level of referred or specialty care. As long as the mandatory referral/authorization information is received and documented prior to the service, the physical card is not required.

Retroactive Referral/Authorization

A retroactive or backdated referral/authorization is considered an inappropriate and unacceptable referral. A referral/authorization is required prior to Medicaid managed care covered services being performed. Failure to receive the referral/authorization prior to Medicaid managed care services being performed will be cause for non-processing or denial of the claim.

Verifying Referrals

When verifying or back tracking referrals previously received from sources other than the recipient's PCP, the last referring provider should be contacted to confirm the authorization information; i.e., hospital consult services, further referred specialty services, DME, Home Health, etc.

Completion of Referral/Authorization

When the specialty provider has **completed** treatment, for which the eligible Medicaid recipient was referred/authorized, the PCP should be made aware that the service has been completed; i.e., Return referral card, provide progress notes, etc.

SOUTH DAKOTA MEDICAID MANAGED CARE INPATIENT/OUTPATIENT HOSPITAL PROVIDER

SOUTH DAKOTA MEDICAID MANAGED CARE - HOSPITAL

INFORMATION SHEET

This information sheet pertains to the South Dakota Medicaid Managed Care program in relationship to hospital providers. The contents of this information sheet are Managed Care covered services specific to: emergency services, inpatient services, outpatient services, and independent services.

EMERGENCY SERVICE -- Non-Managed Care

An "emergency" medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (2) Serious impairment to bodily functions; or
- (3) Serious dysfunction of any bodily organ or part.

NOTE: The physician, PA, or NP on duty or on call at a hospital must determine whether the individual requires emergency hospital care. Emergency hospital service does not include that care for which treatment is available and routinely provided in a clinic or physician's office.

Emergency services are outside of the managed care program. When a Medicaid managed care recipient requires emergency care, a referral/authorization is not required.

DURATION OF EMERGENCY SERVICE:

All medical services related to an emergency admission and provided on the premises are considered emergency services. This includes consultant services, prescriptions, therapy, etc. For billing purposes, the emergency condition continues through hospital transfers if necessary, until the recipient is discharged from hospital care.

FOLLOW-UP SERVICES INCIDENTAL TO AN EMERGENCY ROOM VISIT:

Upon discharge, all medically necessary follow-up services incidental to an emergency room visit provided to South Dakota Medicaid Managed Care recipients, whether the initial emergency room service was covered by Medicaid or not, must be referred/authorized back to their Primary Care Provider. The patient's PCP will determine the need for a specialty referral and follow-up treatment will be provided appropriately.

EMERGENCY ROOM SERVICE -- Managed Care

<u>Urgent care</u> is defined as care that could be treated by a physician in a clinic; however, the care requested requires attention. In this situation an appropriate medical screening is necessary. The ER room and physician charges are covered under Medicaid if non-referred. Ancillary services are not covered unless there is a referral.

<u>Elective care</u> is not emergent or urgent care and must be referred/authorized by the recipient's primary care provider.

Inpatient/Outpatient Service -- Managed Care

When a Medicaid managed care recipient requires non-emergent medically necessary inpatient or outpatient services, a referral/authorization is required from the PCP or Designated Covering Provider. Once a specialty provider has received a referral/authorization the specialty provider may further refer/authorize for medically necessary covered services--such as inpatient/outpatient services.

Inpatient Service -- Non-Managed Care

A Medicaid eligible recipient who is admitted prior to becoming an eligible participant in the Managed Care Program, i.e. the recipient is admitted June 27, 2006, and is discharged July 7, 2006. Managed Care participation for this recipient begins July 1, 2006. The complete inpatient stay is Non-Managed Care. All medically necessary medical services provided during this stay are outside of Managed Care.

Independent Service -- Non-Managed Care

If your facility provides a LAB service without the recipient present, this is classified as an independent service and is outside of managed care.

SED/SPMI - Mental Health Services ONLY -- Non-Managed Care

Mental Health services provided to persons diagnosed either Severely Emotionally Disturbed or Severely and Persistently Mentally Ill are exempt from Managed Care.

Dental Services -- Non-Managed Care

Dental/Orthodontic related services, such as a physical prior to oral surgery, are outside, or exempt from Managed Care.

A HOSPITAL WILL NOT REFUSE TO SEE ANY INDIVIDUAL WHO MAY REQUIRE CARE

SOUTH DAKOTA MEDICAID MANAGED CARE

APPENDIX

ADDENDUM TO THE PROVIDER AGREEMENT

To Participate in the South Dakota Medical Assistance PRIME Program

This document serves as a formal addendum to your South Dakota Medical Assistance Provider Agreement and enables you to become an enrolled PRIME primary care provider (PCP). Further explanations of PCP requirements are described in the *Managed Care Provider Manual*.

D. PROVIDER AGREES TO THE FOLLOWING

- 1. Provider agrees to provide comprehensive primary health care services for Medical Assistance recipients who are enrolled with your practice. In addition to requirements in the *Provider Agreement*, Primary care providers must have hospital privileges and a current Drug Enforcement Agency (DEA) number to prescribe controlled substances.
- 2. Provider agrees to be the health care case manager. This includes: reviewing monthly paid claims report and notifying the Division of Medical Services of any discrepancies, cooperating with the Division of Medical Services staff regarding provider's case management procedures and history, and to meet with the Division of Medical Services staff upon request of the Department.
- 3. Provider has not been restricted from participating in any private, Federal or State health insurance program or knowingly has a business relationship or subcontract with individuals restricted from participating in any private, Federal or State health insurance program.
- 4. Provider agrees to refer recipients for specialty care, hospital care, and other services when medically necessary and to sign and document referrals.
- 5. Provider agrees to provide for reasonable and adequate hours of operation and make available 24-hour, 7 days per week access by telephone for information, referral, and treatment needs during non-office hours.
- 6. Provider agrees not to refuse an assignment or disenroll a recipient or otherwise discriminate against a recipient solely on the basis of: age, sex, race, color, national origin, marital or economic status, physical or mental disability, service utilization and health status except when a recipient's illness or condition is better treated by another provider type.
- 7. Provider agrees to comply with any applicable Federal and State laws that pertain to recipient's rights, and ensure that its staff and affiliated providers take those rights into account when furnishing services to recipients. Recipient rights include: To be treated with respect and with due consideration for his or her dignity and privacy. To receive information on available treatment options and alternatives presented in a manner appropriate to the recipient's condition and ability to understand. To participate in decisions regarding his or her health care, including the right to refuse treatment. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. To receive a copy of his or her medical records, and to request that they be amended or corrected. And be free to exercise his or her rights without adverse consequences.
- 8. Provider agrees to notify the recipient and the Division of Medical Services in a direct and timely manner of the desire to remove the recipient from the caseload because the recipient/provider relationship is not mutually acceptable. Reasons must be considered "good cause", explained in writing, non-discriminatory, generally applied to the provider's entire patient base, and approved by the Division of Medical Services.

- 9. Provider agrees to keep the recipient as a patient until another provider is assigned.
- 10. Provider agrees not to conduct direct or indirect marketing activities specifically intended to influence recipients to enroll with the PCP or disenroll from another PCP.
- 11. Provider agrees to accept the established monthly case management fee for each eligible recipient under their caseload. Recipients who select primary care providers which are enrolled as rural health clinics, federally qualified health centers or Indian Health Services are not "eligible recipients" for purposes of receiving such case management fee only.
- 12. Provider agrees not to have a caseload that exceeds 750 recipients and to accept recipients in the order in which they enroll with the primary care case manager
- 13. Provider agrees to be disenrolled as a Provider for failure to comply with Provider requirements.

E. MEDICAL SERVICES AGREES TO THE FOLLOWING:

- 1. Provide a current list of recipients assigned to the Provider.
- 2. Reimburse the Provider a monthly case management fee for each enrolled and eligible recipient on the Provider's caseload.
- 3. Notify the Provider of any changes in the *Managed Care Provider Manual* as they occur.

This addendum agreement is binding upon the p	parties effective

PROVIDER NAME:	FEDERAL TAX I.D. NUMBER:
	TAX I.D. NAME:
Authorized Signature NAME/TITLE:	UPIN NUMBER:
PROVIDER SPECIALTY:	ADMINISTRATOR/OFFICE MANAGER:
DATE:	
TO BE COMPLI	ETED BY MEDICAL SERVICES
APPROVED BY: Larry Iversen, Division Director	PROVIDER NUMBER:
DATE:	NPI NUMBER:
	ADDRESS:

MC CLINIC NUMBER:

DSS Nondiscrimination Policy: It is the policy of the Department of Social Services (DSS) to make sure that applications for program benefits and services are made available to everyone and that program benefits are granted to all who meet eligibility standards. DSS staff, programs and policies must not discriminate against clients or applicants for services because of race, color, sex, age, disability, religion and national origin. DSS must also provide fair and equal access to all of its programs and services for people with disabilities; this includes both physical access to buildings and access to programs and services. To file a complaint of discrimination write: DSS Division of Legal Services, 700 Governors Drive, Pierre, SD 57501-2291 or call: (605) 773-3305. If you have a question regarding program services, please contact your nearest DSS office. 100 copies of this document were printed by DSS at a cost of ? cents per copy. DSS/Oct06